White House Releases 2012 Budget

On Feb. 14 the Obama administration released its proposed budget for fiscal year 2012. Included were the following budget proposals.

Two-year fix for Medicare physician payment. Under the proposed budget, Medicare reimbursement for physicians would be frozen at the current level for two years. According to *BNA's Health Care Daily Report,* this is an indication that neither the White House nor Congress is interested in grappling with a permanent solution to the ongoing sustainable growth rate (SGR) issue at the present time.

NIH slated to receive $32 billion. The National Institutes of Health (NIH) would receive $32 billion in FY 2012, a 2.4 percent increase over NIH's FY 2010 funding, BNA reports. Under the proposed budget the National Cancer Institute (NCI) would receive a funding increase of nearly $1 billion for FY 2012.

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Funds for Cures Acceleration Network. The proposed budget includes $100 million for the Cures Acceleration Network, a program approved by the Affordable Care Act (ACA) to award NIH grants to biotechnology companies, universities, and patient advocacy groups to bridge the gap between basic science discovery and its application to treatment, BNA reports.

Fraud and abuse funding nearly doubled. The proposed 2012 budget includes $581 million in discretionary spending for the Health Care Fraud and Abuse Control account, BNA reports, nearly double the $311 million funded in the continuing resolution for FY 2011.

The 2012 proposed budget documents are available online at: *http://www.gpo.gov/fdsys/* and *www.hhs.gov/about/FY2012budget/fy2012bib.pdf*.

CMS Delays April 1 Deadline for Medicaid RAC Program Implementation

In a February 1, 2011, bulletin, the Centers for Medicare & Medicaid Services (CMS) announced that "States will not be required to implement their RAC programs by the proposed implementation date of April 1, 2011. Instead, when the Final Rule is published, it will indicate the new implementation deadline. We anticipate the final rule will be issued later this year."

Medicaid RACs (Recovery Audit Contractors) were created under the Patient Protection and Affordable Care Act and are designed to review and recover claims for improper payments, underpayments, and overpayments.

CMS Selects "Conveners" for Imaging Demonstration

CMS announced Feb. 2 that five health systems have been selected as "conveners" (or participants) in the Medicare Imaging Demonstration (MID), according to the Feb. 4 *BNA's Health Care Daily Report.* The conveners will help to recruit physician participants to the MID. CMS is seeking participation by 2,500 to 3,500 physicians from 500 to 650 practices that vary in size, specialty mix, type (academic and private practice), and location. The five conveners are:

- Brigham & Women's Hospital
- Henry Ford Health System
- Maine Medical Center-Physician Hospital Organization
- University of Wisconsin-Madison
- National Imaging Associates.

The two-year Medicare Imaging Demonstration project will assess whether the use of decision support systems can improve quality of care and reduce unnecessary radiation exposure by promoting appropriate ordering of advanced imaging services. The MID focuses on three advanced diagnostic imaging modalities: magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine. Included in the demonstration are 11 advanced imaging procedures: Spect MPI, MRI lumbar spine, CT lumbar spine, MRI brain, CT brain, CT sinus, CT thorax, CT abdomen, CT pelvis, MRI knee, and MRI shoulder.

A CMS fact sheet about the MID project is available online at: *http://www.cms.gov/DemoProjectsEvalRpts/downloads/AUI_Fact_Sheet.pdf*. Additional information is available at: *http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1222075*. ACCC members interested in participating in the demonstration project should visit the CMS website listed above for more information or contact Matt Farber at: *mfarber@accc-cancer.org*.

EP Registration for EHR Incentive

Can a third-party be designated to register eligible professionals (EPs) for the CMS EHR Incentive? The answer from CMS is no—not at the present time. In a Feb. 7 post to the Physicians Listserve, the agency stated:

"At this time, there is no method available for a third-party to register multiple eligible professionals (EPs) for the Medicare and Medicaid EHR

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Incentive Programs." However, in May, the agency plans to implement functionality that will allow an EP to designate a third-party to register and attest on his or her behalf. CMS will release detailed information about that process when it is available.

For more on the Medicare & Medicaid EHR Incentive Programs and to register, go to: *http://www.cms.gov/EHRIncentivePrograms*. For information on your state's Medicaid EHR Incentive launch visit: *http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp*.

CMS to Reprocess Claims Affected by ACA & 2010 MPFS Changes

In February 2011, CMS announced that the agency would begin reprocessing claims affected by provisions in the ACA and corrections to the 2010 Medicare Physician Fee Schedule (MPFS). ACA was signed into law on March 23, 2010. Various provisions in ACA were implemented some time after their effective date. Corrections to the 2010 MFPS were implemented concurrently with ACA and had an effective date retroactive to Jan. 1, 2010.

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-schedule claims will be reprocessed, CMS said. In a post to the agency's Physicians Listserve, CMS states:

We expect that this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

In the majority of cases, you will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your claims. Please do not resubmit claims because they will be denied as duplicate claims and slow the retroactive adjustment process. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount (MPFS and ambulance fee schedule) cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, we believe that these circumstances fall under the "good cause" criteria described in the Claims Processing Manual, Publication 100-04, Chapter 34, Section 10.11 (http://www.cms.gov/manuals/downloads/clm104c34.pdf). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contactors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims. Underpayments will be included in your next regularly scheduled remittance after the adjustment. Overpayments resulting from institutional provider (e.g., hospitals, inpatient rehabilitation facilities, etc.) claim adjustments will be offset immediately, regardless of the amount, unless there are insufficient funds to make the offset. When these overpayments cannot be offset, the amounts will accumulate until a $25 threshold is reached. At that time, a demand letter will be sent to the institutional provider. When a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than $10, your contractor will not request repayment until the total amount owed accrues to at least $10. See the Financial Management Manual, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2 (www.cms.gov/manuals/downloads/fin106c04.pdf) for more information.

Contact your Medicare claims administration contractor with any questions.

Update on Fulvestrant Claim Denials

The Association of Community Cancer Centers (ACCC) and the American Society of Clinical Oncology (ASCO) report that in January some members experienced denials of claims for fulvestrant at a dose of 500 mg based on a "medically unlikely edit" (MUE) for fulvestrant.

ASCO reports that the CMS contractor responsible for the National Correct Coding Initiative and MUEs has a workaround for fulvestrant claims, as follows:

In this instance only, providers may submit their claims prior to April 1 by reporting J9395 on two lines of a claim utilizing modifier 59 with the code on one claim line and be paid for the 500 mg dose of fulvestrant. On each claim line the provider may report 10 units of service.

Providers may also delay submission of their claims until April 1, 2011, when CMS will modify the MUE value for this code in its next regularly scheduled update. Providers who have already had claims denied due to this MUE value, may resubmit their claims or appeal them after April 1, 2011, to their local claims processing contractor.

ACCC will continue to monitor the situation. Please contact Matt Farber at: *mfarber@accc-cancer*, if you experience similar problems with this drug or others.

Abbreviated Titles for ICD-10 Code Sets Released

CMS has released abbreviated titles for both the ICD-10 Clinical Modification (CM) and ICD-10 Procedural Classification System (PCS) code sets, according to the Feb. 28 *BNA Health Care Daily Report.* The ICD-10 abbreviated titles are available at: *https://www.cms.gov/ICD10/01_Overview.asp#TopOfPage*. CMS also posted ICD-10 Medicare-severity diagnosis-related group draft definitions on its website at: *http://www.cms.gov/icd10manual/fullcode_cms/p0001.html*.